of high quality primary health care services. This will require strengthening capacity at the local level to finance and implement these services. It will require correction of problems in key health systems, including clinical training, supervision, use of data for decision making, and logistics management. The capacity of the NGOs and private sector must also be further strengthened to promote program sustainability.

- IR3: *Women, families and communities are empowered to take responsibility for improving health*

Effective communication and media are needed at all levels to advocate for sustained improvements in health of women and children. Individuals and communities need information about appropriate healthy behaviors. Also, they need to be empowered to demand higher quality primary health care services. Fundamental changes in public health behavior, perceptions of health care services, and awareness that maternal and child survival is a human right, will be addressed through building community action for these issues. Mass media and other forms of communication will be used to inform the public. USAID has been asked by the Minister of Health and Social Welfare to develop a communications and advocacy program for decentralizing the *Healthy Indonesia 2010* paradigm. This new paradigm shifts the health program from a highly centralized program focused on curative care to a decentralized one based on prevention.

C. Gender Integration

The objective of the health program is to empower women, especially the poor, by improving the accessibility and quality of health services such as family planning, safe pregnancy, safe labor and delivery, improved nutrition, and treatment of HIV/AIDS and other sexually transmitted diseases. The training and services provided through USAID's health programs improve women's ability to deliver and raise healthy children and help women to reach their full potential to participate in the economic and political spheres. USAID's street children assistance program emphasizes the girl child, since she faces even greater risk than her male counterparts for transmission of disease, malnutrition and sexual abuse.

One of the most important gender challenges being addressed is getting men to take more responsibility for their families' health by improving male contraceptive use and increasing the involvement of husbands in preparing for obstetric emergencies. The HIV/AIDS prevention program is targeting the behavior of high-risk groups of men (e.g., seamen, mining laborers, clients of prostitutes, men who have sex with men, etc).

III. Funding and Financial Plan

The financial plan for the program "Protecting the Health of the Most Vulnerable Women and Children" is set forth in Attachment A: Table 1, Revised Financial Plan (July 2001). From the date of the Strategic Objective Agreement onwards, obligations will be made in accordance with

this Budget. Future USAID obligations under the Agreement are subject to the availability of funds and mutual agreement of the Parties to proceed.

A. Funds Supporting the Government of Indonesia Program

USAID funding will be provided to cooperation agencies, grantees, contractors and non-governmental organizations (both U.S. and Indonesian) for the following purposes, including but not limited to:

- Technical Assistance
- Training
- Research and surveillance
- Medical Supplies and commodities
- Assessments, performance monitoring and evaluations
- Audits
- Other purposes as deemed appropriate

Funding will be provided directly by USAID in the form of Grants, Cooperative Agreements or Contracts to U.S. organizations and universities, International Private Voluntary Organizations (PVOs), and Indonesian Non-Governmental Organizations (NGOs) which are working as "implementing partners" to implement program activities and achieve program goals and objectives.

B. Other USAID Program Support Obligated Outside this Agreement

In addition to the amount that will be obligated under this Agreement as shown in Attachment A: Table 1. Revised Financial Plan (July 2001), USAID will also contribute additional technical and program support for activities that may be obligated outside of this Strategic Objective Agreement. These USAID-funded projects are working in Indonesia to contribute to the overall Objective and Results of the Agreement, but funding may be provided by USAID/Washington or USAID/Indonesia through other financial mechanisms, as described in Section VI. Implementation Arrangements. All funding contributing to the overall Objective and Results of the Agreement count toward the Total Estimated USAID Contribution in Section 3.1. (b) of this agreement.

IV. Results to Be Achieved, Activities and Indicators to Measure Accomplishments

The Objective of this Agreement is to Protect the Health of the Most Vulnerable Women and Children. In order to meet the objective, the Parties to this agreement agree to support activities that will achieve the following Intermediate Results (IRs):

IR1: Policy environment for reproductive and child health, HIV/AIDS and infectious diseases improved;

IR2: Health service systems strengthened to improve access, quality and sustainability; and

IR3: Women, families and communities empowered to take responsibility for improving health.

There are five planned technical areas or program components in which activities are implemented in order to reach the Strategic Objective and Intermediate Results:

1) Family Planning
2) Maternal and Child Health and Nutrition
3) HIV/AIDS and Infectious Diseases
4) Complex Emergency Responses
5) Decentralization

Additional technical areas or program components will be included as deemed appropriate.

Activities and interventions will be selected based on the following principles and factors:

- Target the most vulnerable segments of the population (pregnant and lactating women, children under five and internally displaced people);
- Maintain access of the poor to facilities and services in selected geographic areas as identified by surveillance data;
- Support a cost-effective, preventive (as opposed to curative) health service paradigm;
- Preserve progress already made;
- Build on existing GOI policies and Indonesian health infrastructure;
- Build on the GOI's program to strengthen financing mechanisms that will enable low-income segments of the population to pay for health and family planning services;
- Recognize the need to scale up innovative programs in pilot districts.

The sections that follow discuss the results that are expected to be achieved through implementation of each component; describe illustrative activities required to attain these results; and specify indicators which will be used to monitor achievement of results. Some activities may contribute to the achievement of more than one Intermediate Result.

A. Family Planning Component

The overall result to be achieved in this component is increased acceptability and consistent use of high quality family planning services. The intermediate results required to achieve this overall objective are:

- An enhanced policy environment that reflects gender sensitivity;
- Increased capacity of public, private, non-governmental organizations and communities to plan, manage, monitor and provide high quality family planning services;
- Increased use of effective communications and appropriate advocacy.

Illustrative activities for the family planning component include:

Advocacy to senior decision-makers at national, provincial and district levels to maintain commitment to *family planning* at the local level (IR1)

Addressing *contraceptive self-sufficiency* and other program sustainability issues (IR1)

Developing *national health quality standards* and improving compliance at the district levels (IR1)

Ensure that quality and informed choice are instituted as hallmarks of the national *family planning* program, and implemented within a framework of reproductive health rights. (IR1,2,3)

Improve *logistics management and delivery systems* for contraceptives (IR2)

Ensure policies to improve access to *reproductive health information and services for adolescents*, a growing group which comprises over 34% of the population (IR1,2,3)

Assist with data collection, analysis, and dissemination of Indonesia Demographic and Health Survey (IDHS) 2002 (IR 1)

Illustrative indicators to monitor results performance for the family planning component include:

- Maintenance and eventual increase in the national modern contraceptive prevalence rate and in program areas (SO level)
- Continuation rates for selected methods increase (SO level)
- Policies analyzed and recommendations made to BKKBN on a number of critical issues, including but not limited to: male participation, voluntary surgical contraception, and adolescent reproductive health (IR 1)
- Improved quality of care in family planning program and facilities (IR 2)
- Skills of health, family planning, and adolescent reproductive health providers and counselors improved (IR 2)

- Contraceptive commodity logistics system improved (IR2)
- Increased use of communication tools for client-provider interaction (IR3)

B. Maternal and Child Health and Nutrition (MCHN) Component

The overall results to be achieved in this component include reduction of maternal, neonatal and under five mortality and morbidity and improved nutritional status of women and children.

Illustrative Activities for the MCHN component include:

- Advocacy to senior decision-makers at national, provincial and district levels to maintain commitment to *maternal/neonatal/child health and nutrition* at the local level (IR1)
- Increase participation of women's community groups in defining health needs and in advocating for high quality, responsive *family planning, and maternal/neonatal and child health programs (IR1)*
- Improve technical capacity at local levels (including midwives, public sector officials and NGOs) to deliver an integrated package of interventions: *maternal nutrition and iron supplementation, management of pregnancy and delivery, infection prevention, tetanus toxoid immunization, post natal care for mothers and newborns, hepatitis B vaccination* in the first week of life, counseling on *breast feeding, immunization, hygiene and diarrhea prevention (IR2)*
- Improve *clinical training systems and interpersonal communication & counseling* for family planning and maternal health (IR2)
- Improve *micronutrient* status of children through vitamin A supplementation for infants 6-11 months and children 12-59 months in focal urban areas (IR2)
- Improve *nutritional status* of vulnerable infants 6-12 months through targeted infant feeding and strengthening use of the integrated village health post (IR 2)
- Ensure that health and nutrition *surveillance systems* are functioning at all levels, and local authorities for planning and management are using that data (IR2)
- Increase knowledge and utilization of *micronutrient rich foods* to improve nutrition *(IR3)*

- Increase awareness of the value of the girl-child and responsible parenting in urban communities to prevent school dropouts and reduce the numbers of *urban street children* (IR2)

- Strengthen capacity of NGOs and local governments to plan and manage programs serving the special needs of *urban street children (IR3)*

Illustrative indicators to monitor results performance for the MCHN Component include:

- An increase in the proportion of births attended by a skilled provider in program areas (SO level)

- National maternal health standards accepted by MOH and professional organizations and implemented in program areas (IR1)

- Decrease in proportion of retained placenta among all births managed by trained midwives (IR2)

- Proportion of pregnant women in program areas having/knowing at least three out of six components of comprehensive birth planning (IR3)

- An increase in the proportion of children with complete immunizations before age one year (IR2)

- An increase in the proportion of newborn-mother pairs seen at home by skilled provider within 7 days of birth (IR2)

- An increase in Vitamin A capsule coverage among children 6-59 months of age in targeted areas. This indicator will be disaggregated for the age group 6-11 months in urban slum areas, in all target areas (urban and rural), and for the age group 12-59 months in target areas (urban and rural) (SO level)

- Increase in proportion of households with children 6-12 months who received Vitadele, a supplementary food (IR2)

- Increase in proportion of under-5 children who are weighed at posyandu (integrated health post) each month (IR3)

- Increase in the number of new initiatives influencing local policy on street children developed in program impact areas (IR1)

- Improved access to tetanus toxoid immunizations among female street children age twelve and older (IR2)

C. HIV/AIDS and Other Infectious Diseases Prevention Component

The overall results to be achieved in this component include prevention of the transmission of sexually transmitted infections (STIs) and HIV/AIDS and control of re-emerging infectious diseases, specifically TB and malaria. Intermediate Results include:

- Increased risk reduction behavior and practices among individuals at high risk for HIV and sexually transmitted infections (STIs)

- Strengthened quality, accessibility and utilization of prevention and control services for individuals at risk of STI/HIV/AIDS, TB and malaria

- Enhanced capacity and quality of Government of Indonesia HIV/STI surveillance systems and their use in key decision-making

- Strengthened capacity of local organizations to plan, finance, manage and coordinate HIV/STI, TB and malaria responses

- Increased leveraging of programmatic interventions and financial resources

Illustrative activities for the HIV/AIDS and Infectious Diseases component include:

- Advocacy to senior decision-makers at national, provincial and district levels to maintain commitment to *HIV/AIDS* prevention and other infectious diseases prevention services at the local level (IR1)

- Support the development of appropriate national and local intravenous drug use policies to reduce the spread of *HIV/AIDS (IR1)*

- Ensure that HIV/AIDS *surveillance systems* are improved at all levels, and local authorities for planning and management are using that data (IR2)

- Improve *logistics management and delivery systems* for essential drugs to treat sexually transmitted infections (IR2)

- Strengthen quality, accessibility and utilization of *HIV/STI* prevention services and develop local capacity to adapt *HIV/AIDS* universal precaution and infection control practices (IR2)

- Implement the DOTS Strategy for *TB control (IR2)*
- Implement epidemic malaria containment interventions in Menoreh Hills, Central Java (IR2)
- Mobilize *care-seeking behavior for STIs to prevent HIV/AIDS (IR3)*
- Promote *condom use* among high risk populations (female and male sex workers and their clients, as well as men who have sex with men and injecting drug users) (IR3)
- Promote *private sector participation* in HIV/STI prevention efforts among their employees (IR3)

Illustrative indicators to monitor results performance for HIV/AIDS and Infectious Diseases component include:

- An increase in the provincial/district budgetary contribution to HIV/AIDS/STI programs to the provincial/district AIDS Commission (KPAD) budget over the previous year (IR1)
- An increase in the percentage of commercial sex establishments with condoms always available on site for client use (IR1)
- An increase in the percentage of patients presenting with an STI at program collaborating STI clinics who are correctly diagnosed and treated according to GOI treatment protocols (IR2)
- An increase in the percentage of program collaborating clinics reporting adequate supply of essential STI drugs (IR2)
- An increase in the percentage of districts/provinces utilizing annual HIV/AIDS sero and behavioral surveillance (IR2)
- An increase in the regular dissemination of HIV/STI sero and behavioral surveillance data by the Ministry of Health and Social Welfare/CDC (IR2)
- An increase in the percentage of sex workers and male clients reporting use of condom during the most recent commercial sex encounter in the last month. This indicator will be disaggregated by female and male sex workers and male clients (IR3)
- An increase in the percent of intravenous drug users reporting the use of safe injecting equipment during the last 30 days. (IR3)
- An increase in the provincial/district budgetary contribution to the provincial/district laboratory services supporting the TB program (IR1)

- An increase in the proportion of TB cases in the focus provinces/districts that are diagnosed by smear microscopy (IR2)

- A reduction in malaria morbidity and mortality in intervention areas (IR2)

- A reduction in the monthly parasite incidence rates for malaria in intervention areas (IR2)

D. Complex Emergency Responses Component

The overall result to be achieved in this component is protecting the health of internally displaced women and children affected by conflicts.

In conjunction with *humanitarian relief* efforts in provinces that have been affected by violent conflict, activities under the SOAG are providing support for selected emergency health and child survival activities managed through international PVOs. Programs include but are not limited to infant feeding activities, health/hygiene education, water and sanitation, and primary health care including reproductive health in West Kalimantan, Maluku and North Maluku, Madura and Aceh. Additional areas may be included as warranted.

Because this component involves the need to act quickly and appropriately, the results expected are short term and vary from location to location. Illustrative expected results are:

- nutritional status of displaced children and families improved (IR2)

- health of women and children affected by conflict improved by support for health service delivery at health posts (IR2)

- reproductive health of women that tend to be neglected during conflict and in the emergency camps will improved (IR2)

E. Decentralization Component

The overall result to be achieved in this component is strengthened public-private sector partnerships to promote preventive health services in a decentralized Indonesia. Illustrative activities are:

- Establish a Health Coalition consisting of NGOs, local health boards and advocacy groups to develop a public information and media program in support of *Healthy Indonesia 2010* (IR1)

- Support the MOH Decentralization Unit to provide management and leadership skills to district level managers of public health programs (IR1)

- Support BKKBN to provide management and leadership skills to family planning managers at the district level

F. Activities Not Supported

Described below are activities that will not be supported by this program:

Foreign assistance legislation prohibits the use of funds by USAID for: (a) the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions, (b) the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilization; (c) any biological research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilizations as a method of family planning.

- This program will not support infertility treatments. However, it does support efforts to prevent the spread of STIs, a major cause of infertility.

- This program will support safe obstetric delivery care and timely detection and case management of complications. However, although included in the WHO package of essential obstetric services, the program will not support caesarean sections, blood transfusions, or the general provision of essential drugs, nor medical intensive care approaches for neonate infants.

- This program will not support production facilities for Oral Rehydration Salts and essential drugs. The program will not support the construction of health facilities, hospitals, or laboratories.

- The program recognizes the need for treatment of opportunistic infections for individuals living with HIV/AIDS. However, given the program's primary focus on preventing HIV/AIDS, the program will not supply or distribute drugs to mitigate the impact of HIV/AIDS.

- The program will not support long-term training. The program focus is on strengthening the National Clinical Training Network within Indonesia for both family planning and maternal health, training master trainers, developing training curricula, and supporting the MOH pre-service education and in-service training efforts.

- The program will not support basic research. Program research focuses on short-to medium survey research, related to targeting resources and the impact of the crisis. Program research focuses on operations research to improve service delivery approaches.

- The program will not support curative services or acute care.

V. Roles and Responsibilities of the Parties

A. Oversight and Coordination

Oversight and coordination for this program will be provided by: (a) an Executive Steering Committee, (b) Responsible Person(s), (c) Activity Teams, and (d) a SOAG Secretariat.

a. The Executive Steering Committee will be comprised of the following representatives:

- USAID Strategic Objective Team Leader for Health, Population and Nutrition and his/her designee;
- MOH: the Director General of Community Health; the Director General of CDC & EH; the Head of National Institute Health Research and Development; the Secretary of SOAG Executive Steering Committee.
- BKKBN: the Deputy for Family Planning and Reproductive Health; the Deputy for Planning and Family Information
- MOWE: the Secretary to the State Minister

The Executive Steering Committee will meet semi-annually (or more frequently as required) to provide overall policy guidance; to assure effective coordination among technical components; to help resolve implementation problems; to review program performance achievements; and to review implementation of SOAG activities.

b. Responsible Person(s) (RP) will be established for the following program components:

1) family planning (RP for BKKBN);
2) maternal/child health and nutrition (RP for Directorate General of Community Health; RP for National Institute Health Research and Development; RP for MOWE);
3) HIV/AIDS and infectious diseases prevention (RP for Directorate General of Communicable Disease Control and Environmental Health);
4) Complex emergency responses (RP for Directorate General of Community Health and RP for Health and Social Problems Unit)
5) Decentralization (RPs comprised of Directorate General of Community Health and BKKBN)

The Responsible Person(s) represented by the Director General of Community Health, Director General of Communicable Disease Control and Environmental Health, Director General of Health and Social Problems, Head of National Institute Health Research and Development, Deputy for Family Planning and Reproductive Health of BKKN, Secretary to the MOWE or

his/her designee will meet quarterly, or as needed, with Activity Teams to discuss technical implementation issues, coordinate activities, and make recommendations on SOAG implementation to the various Activity Teams responsible for day to day implementation of the activities coordinated by a particular RP. The RP will review progress and serve as a forum to discuss issues related to any Activity under its coordination. These RP will be the forum through which the Activity Teams share information with the Executive Steering Committee concerning progress made in achieving the results desired for the **Protecting the Health of the Most Vulnerable Women and Children** program.

The RP will ensure that the Activity Teams are facilitating the implementation of the various technical components of the SOAG, that performance monitoring plans are developed and that results are being achieved, disseminated and shared. The RP will report on the status of activities for which he/she has responsibility on a semi-annual basis to the SOAG Executive Steering Committee.

c. Activity Teams will work with the implementing partners and USAID Activity Managers for the various technical activities undertaken through the award of a Grant, Cooperative Agreement or Contract from USAID. The respective Activity Teams, which may include representatives from Central, Provincial or District levels and from MOH, BKKBN and/or MOWE will meet on an as need basis to discuss implementation issues, including, for example:

1. Review of annual workplans from implementing partners to ensure activities in the workplans are complementary, not duplicative, and technically appropriate.

2. Identification of technical assistance, training and institutional strengthening and capacity building needs.

3. Coordination with other related GOI and Donor activities related to the technical program component.

4. Review performance monitoring plans, assist implementing partners in developing annual targets for results indicators, and monitor achievement of results.

5. Review performance reports submitted by the implementing partners.

d. A SOAG Secretariat will be established to support the activities of the SOAG Executive Steering Committee, the Responsible Person(s) and their associated Activity Teams, the SOAG implementing partners, local governments, and USAID. As a convenience to USAID and GOI, the Sustaining Technical Achievement in Reproductive Health (STARH) program has been designated to administer financial, technical and administrative support for the SOAG secretariat.

The SOAG Secretariat will facilitate the collaborative efforts by MOH, BKKBN, MOWE, USAID and the primary implementing partners for smooth implementation of program activities, identification and resolution of issues, linkages to other Donor activities and the ongoing process of decentralization.

B. Grantee Responsibilities

The Parties are responsible for setting national policy as well as providing services through the national public health system. The Government is currently undertaking major reforms in the health sector, including enhanced decentralization authority for provinces and districts. As such it is expected that provincial and district levels of BKKBN, MOWE and MOH will play an important role in the implementation of the Agreement, **Protecting the Health of the Most Vulnerable Women and Children.**

It is also expected that the Government of Indonesia will continue to acknowledge the important role that international PVOs and Indonesian NGOs will play in implementing the GOI health care delivery system, and in implementing this program with funding provided by USAID. The GOI is expected to fulfill its responsibility to facilitate visa and assignment approvals; fee, tariff and tax exemptions; and customs clearances in accordance with Sections 6.3, 6.4, 6.5, 6.6. and B.4 of this Agreement.

The MOH, BKKBN, and MOWE will each designate official GOI counterpart representatives to serve on the Executive Steering Committee. The MOH, BKKBN and MOWE will also designate other representatives to serve as official GOI counterparts as the Responsible Person(s) and the associated Activity Teams.

The Government of Indonesia is responsible for in-kind contributions as explained in Section 3.2 of this Agreement.

With respect to all organizations receiving funds directly from USAID under the Agreement, such as direct USAID contractors or recipients or direct USAID non-governmental partners (either U.S. or Indonesian), as indicated in Section VI.A. Grants, Cooperative Agreements and Contracts Awarded by USAID below, the USAID agreement with these entities will contain appropriate audit requirements (including audit thresholds) for these funds. Funding for such audits will be provided from Agreement funds where appropriate.

C. USAID Responsibilities

USAID has overall responsibility for technical decisions regarding the cost-effective use of resources under this Program. The USAID Strategic Objective Team leader for the Health, Population and Nutrition (HPN), or her/his designee, will serve as the overall Cognizant Technical Officer for this program. However, other USAID HPN team members may work with

the associated Activity Teams and will participate in the development and review of annual workplans for all technical components and their associated activities.

USAID will approve proposals from implementing partners and inform the GOI when proposals have been approved for funding under the program.

USAID will take full responsibility for procurement and financial management of programs noted above.

USAID will provide technical and administrative personnel required to implement the activities.

USAID will monitor and report on all implementation and achievements of the program.

D. Implementing Partner Responsibilities

USAID cooperating agencies, grantees and contractors, international Private Voluntary Organizations (PVOs), and Indonesian Non-Governmental Organizations (NGOs), will play an important role in implementing activities under this program with funding provided to them by USAID.

All implementing partners selected by USAID and the GOI to receive funding under the program will serve on the Activity Team related to their activity and will participate in meetings as requested by the Responsible Person(s) or their program components.

Implementing partners will develop and submit annual workplans for review by their specific Activity Team to ensure that activities in the workplans are complementary, not duplicative, and technically appropriate.

Implementing partners will prepare performance monitoring reports for USAID and the GOI in accordance with the terms of the individual agreements.

VI. Implementation Arrangements

A. Grants, Cooperative Agreements, and Contracts Awarded by USAID

USAID will solicit, manage, finance and take overall responsibility for goods and technical services to be procured which contribute to the Objective of this Agreement, **Protecting the Health of the Most Vulnerable Women and Children.** USAID may use various different procurement mechanisms, such as grants, cooperative agreements, institutional contracts, indefinite quantity contracts, Participating Agreements with other U.S. Government Agencies (PASAs), and Personal Service Contracts (PSCs). This assistance will be used to provide technical assistance and other program support for program implementation.

VII. Monitoring Progress and Evaluating Results

The monitoring and evaluation plans for this program will be developed by each implementing partner and agreed upon with USAID and the appropriate Activity Teams and their associated Responsible Person(s) described in Section V, Roles and Responsibilities of the Parties.

Illustrative indicators to be used in monitoring this program were already provided in Section IV, Results to be Achieved, Activities, and Indicators to Measure Accomplishments.